

Women with HIV presenting at three London clinics between 1985-1992

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Abstract

Objective—To determine the changing patterns of HIV infection in women in three units in London.

Subjects—Three hundred and fifty seven HIV seropositive women who have attended outpatient clinics between 1984 and 1992.

Methods—A retrospective review of data obtained from a computerised database and supplemented by direct inspection of the notes.

Results—The number of newly identified women with HIV has risen steadily over the period of study with a significant shift towards a heterosexual mode of transmission. This is a reflection of increasing numbers of women from Sub-Saharan Africa rather than a rise in the incidence of HIV in women born in the UK.

Conclusions—The increase in women infected by HIV remains predominantly restricted to women in "high risk" groups. Although encouraging, our data should be interpreted with caution since it suffers from the inherent bias of selective testing. Safer sex education and epidemiological surveillance should continue despite the apparent low risk to women born in the UK.

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Introduction

The spread of HIV infection in the UK has been the subject of diverse opinions, with estimates in most cases, significantly exceeding the actual number of cases, causing some to doubt whether there is a heterosexual epidemic in the UK.^{1,2} By December 1992 there were 19,065 reports of HIV infection in the UK, 12.4% of these were women.³ Nationally, the incidence of newly identified individuals has remained stable with 1800-3000 cases a year since 1985.³ There has, however, been a change in the relative importance of different exposure categories. The only group that has shown a year on year rise in the incidence of HIV has been men and women acquiring HIV heterosexually.³ Earlier reports from our own and other departments in London⁴⁻⁶ have suggested this is predominantly "imported" from Sub-Saharan Africa. To determine whether this remains the case, data from our three clinics (1985-1992) was analysed. By the end of

1992, 357 HIV seropositive women had been seen in three outpatient clinics in London.

Methods

The data were obtained from the computerised database in the three units and supplemented by direct inspection of the case notes. The parameters investigated included year in which seropositivity was diagnosed, mode of transmission, country of birth and year of entry to the UK where possible. For women born in the UK who had acquired the infection heterosexually any additional risk factors were also determined.

Results

The number of new cases of women seen with HIV in our units has risen steadily since 1984 with an apparent stabilisation after 1990, whilst the number of new cases of women infected as a result of injecting drug use has fallen after a peak in 1987 (fig 1). There has been a significant shift towards a heterosexual mode of transmission (fig 1) and the major component of this increase is a result of women born in sub-Saharan Africa (fig 2). In women from sub-Saharan Africa, data regarding entry to the UK were available in 52% of cases and 86% of these women had entered the UK in the previous year. The annual incidence of new cases of HIV reported among women born in the UK has remained stable over the period of study and totals 50 (fig 2). Of these women, 30 had a recognised risk factor, eight had a partner who was an intravenous drug user, five women had a bisexual partner, nine had a

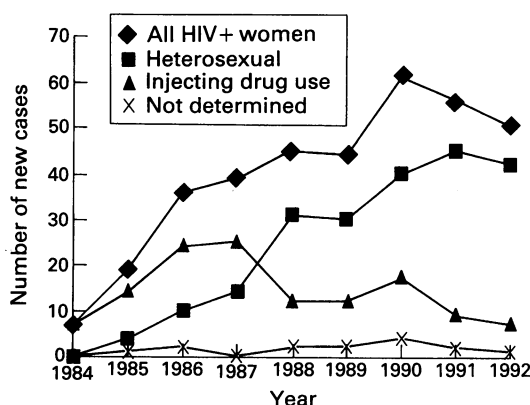


Figure 1 Mode of transmission of HIV in women attending three London clinics.

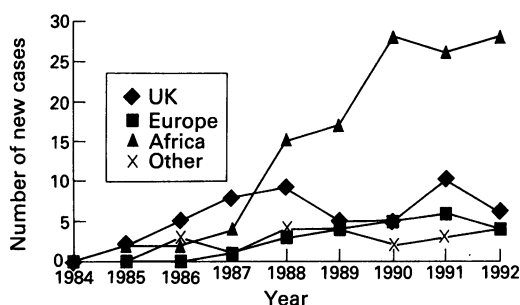
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Figure 2 Country of birth of women infected with HIV heterosexually.



partner from sub-Saharan Africa and eight had a partner known to be seropositive. Twenty women had no apparent risk factors.

Discussion

Although national data published by the Communicable Disease Surveillance Centre (CDSC) provide more detailed information about the epidemiology of HIV infection in women and recognise the fact that increasing numbers of women are reporting exposure to partners from endemic areas, it does not distinguish between immigrants and UK born individuals who have travelled abroad. The main aim of this study was to address this issue. A potential bias was the possibility of patient selection of which clinic to attend for their HIV infection giving a distorted view of the nature of the HIV epidemic in London. However, the effect is likely to have been small since few clinics offer specialist HIV care in the region and our three centres are geographically close and would have allowed for adequate patient choice.

Analysis of our data reveals that the increase in new cases of HIV infection seen thus far is primarily restricted to women born in endemic areas. Most of these women are

recent immigrants and the acquisition of HIV is likely to have occurred before entry to the UK. Whilst this may suggest that the risk to the local "low risk" population can be virtually discounted, the bias inherent in named testing should be recognised. Individuals who are "at risk" are more likely to be offered testing and this may underestimate the extent of infection in heterosexuals assumed to be "low risk". Only anonymous seroprevalence studies which include assessment of risk factors can confirm or deny the true spread of HIV in the "low risk" heterosexual population. Furthermore as the cumulative number of both men and women infected heterosexually increases, the risks of acquiring HIV in the UK will also increase. It has become clear that predictions of the spread of HIV infection are fraught with difficulties and that the debate regarding the risks of a heterosexual epidemic in the UK will continue. It is therefore important that safer sexual practices should continue to be encouraged and continuing epidemiological surveillance maintained both anonymous and selective.

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